Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2016	2016_544527_0018	030976-16	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

Long-Term Care Home/Foyer de soins de longue durée

DUNDURN PLACE CARE CENTRE
39 MARY STREET HAMILTON ON L8R 3L8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 2, 3 and 4, 2016

The complaint log #030976-16 was related to hospitalization and improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Clinical Director, the Director of Nursing, the Social Worker, the Food Services Supervisor and Manager, the resident, dietary staff, housekeeping staff, registered staff and personal support workers (PSWs).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

A review of resident #004's clinical health record indicated their written plan of care in May 2016, was not based on the May 2016, continence management assessment. The continence management assessment identified the resident was continent. Coding for the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed on the same day in May 2016, identified the resident was frequently incontinent.
PSW #150 was interviewed and was not aware that the resident was assessed as being continent when admitted and up to May 2016. The PSW indicated that they had cared for the resident for a long time, had only known the resident to be incontinent most of the time. Registered staff #135 indicated that if the resident was continent that they would have implemented interventions to ensure the resident was able to maintain their continence, and that the continence management assessment and written plan of care were confusing.
Information on the resident's written plan of care identified that the resident was frequently incontinent, and the Information was inconsistent with the assessments completed in May 2016.
The written plan of care for resident #004 was not based on the information from the resident's continence management assessment. [s. 26. (3) 8.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; and (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences.

Resident #005 was admitted to the home in July 2013, and since then the resident had annual care conferences to discuss their plan of care with the interdisciplinary team. The home's policy called "Resident Care Reviews (Care Conferences)", index number RCS C-20, and revised July 2013, directed the receptionist/delegate to notify the family or substitute decision maker (SDM) and request their attendance at the annual care conference. The resident's clinical record was reviewed and there was no documentation that the resident's SDM was invited to the resident's annual care conferences.
The resident was interviewed and they identified that they had been asking for their family member to attend the annual care conferences since they were admitted; however they were not invited and did not know that they could invite their family. In addition, the resident's SDM was interviewed and they indicated that they had been asking to attend the annual care conferences, and that the resident wanted them at the meetings, but they never got invited.
The Social Worker (SW) was interviewed and indicated that because the resident was capable and received notification as to when their annual care conference was scheduled, that they assumed the resident would contact their family member to attend the annual care conferences. The care conference policy was reviewed with the SW and they confirmed that they should have contacted the resident's family member/SDM and invite them to the annual care conferences, with consent of the resident.
The home did not provide an opportunity for the resident's family member/SDM to participate fully in the annual care conferences, and to discuss the plan of care, and any other matters of importance to resident #004 and their family member/SDM. [s. 27. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Resident #005 was transferred to the hospital in October 2016, and was seriously ill. The resident's substitute decision maker (SDM), was not notified by the home of the resident's change in condition and subsequent transfer to the hospital.
The resident's SDM was interviewed and confirmed that they did not know the resident was admitted to the hospital until they received a call from the nurse at the hospital.
The clinical record was reviewed and on the admission record, there was a note, which identified the resident's family member as the emergency contact and a statement, which identified that the SDM was to be notified with any change in status.
The registered staff #125 was interviewed and indicated that the resident made their own decisions about their health, and when a resident was capable, they did not notify the SDM. RPN #125 also indicated that they were not aware of the note on the admission record in the resident's clinical record and as a result of this information, the resident's SDM should have been called.
The Director of Care (DOC) was interviewed and confirmed that the resident's SDM should have been notified of the resident's transfer to the hospital and their change in health status.
The home failed to notify resident #005's SDM of the resident's transfer to the hospital with a serious illness. [s. 107. (5)]

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Issued on this 21st day of December, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.